Between aspiration and reality

New guidance for medical schools has recently been issued by the General Medical Council. Polly Toynbee thinks the document has been written to refute the old complaints about arrogant, god-like consultants. She says that if new doctors come out of medical school imbued with the ethos of the guidance then we might expect a new generation of hypersensitive and thoughtful doctors, but she warns that human nature is bound to intervene

What makes the perfect modern doctor? The General Medical Council has drawn up new guidance for medical schools as a framework on which to base their curriculums and assessments. *Tomorrow's Doctors* (see www.gmc-uk.org/) is an idealistic compendium of the best qualities every new doctor should acquire. If medical schools could indeed turn out doctors moulded to this template, then we should expect a new generation of scholar saints and gentle scientists—wise, knowledgeable, sensitive, collegiate, humble, and good beyond imagining.

It is in the nature of every profession to set itself an ideal character and attempt to impose it as best it can on new entrants. It is also in the nature of humanity to fail that ideal most of the time. Visit any training establishment—of barristers, solicitors, police, nurses, or even journalists (a low trade, hardly a profession)—and you will find the most exalted sentiments imparted to the fresh faced young trainees who dutifully note it all down and deliver it back at examination time in well rounded essays on the ethics and best practice of their future calling. Article one of the Press Code as taught to every fledgling reporter is guaranteed to draw ribald laughter from any audience: "Newspapers and periodicals should take care not to publish inaccurate, misleading or distorted material." Sincere young journalists, police cadets, trainee nurses, or indeed medical students may believe every word of their codes as written up on the blackboard, but no sooner do they step out into the real world of their chosen profession than they tumble into the chasm between the ideal and the real. At police stations it is almost a requirement for old hands to knock the idealism out of the inexperienced new recruits. Young doctors and nurses, too, often receive short sharp shocks to their ethics and values. Short cuts, time constraints, and all the exigencies of true life on the hard pressed wards can put these ideals under severe strain. So it is always well to cast a slightly jaundiced eye over the high flown phrases of professions' protestations of their own virtue, as exhibited in their training manuals.

Polly Toynbee

None the less, all professions need to start out with the best of intentions, and there are plenty of those in the GMC's framework. The priorities for the "curricular outcomes" look sensible. (Is a doctor a curricular outcome?) The principles of professional practice are listed in this order: good clinical care (have good standards and practise within your limits of competence), maintaining good medical practice (keep up to date), relationships with patients (get on well with them), working with colleagues (work well together), teaching and training (be a competent teacher), probity (be honest), and health (make sure your own health does not jeopardise patients' health).

There has plainly been much agonising over the exact order in which the various virtues should be listed. So, for example, "The duties of a doctor registered with the General Medical Council" listed on the front page are in a very perverse order, where six "touchy feely" rather modish qualities are listed before the most important clinical one, "keep your professional knowledge and skills up to date." So, bizarrely, we get doctors ordered to be polite and considerate, respecting their patients' dignity and privacy, listening to patients' views, giving patients information, and respecting their rights before we know if the doctor is any good at all at medicine. If asked to choose qualities, most patients would probably rather be cured by a brusque doctor with up to date skills than be listened to and respected by one who had hardly looked at new treatments in the past 20 years.

Between the lines, this whole document reveals the history of the changed expectations that we all have of how doctors should work. It reads as if it were written to refute all the old complaints about arrogant, out of

touch, unfeeling, god-like consultants who wafted through the wards trailing flotillas of terrified students, when medicine was like the old public school system ("suffer the indignities of being a new boy, and one day, my son, all this grandeur will be yours and you too can bully the life out of your juniors while making them do all the work; you too will be able to terrorise your patients, talk over their heads, and tell them what's good for them while they smile up at you in admiring gratitude").

Mercifully, those days are more or less gone, and this document is proof of it. With reduced working hours for junior doctors, and consultants coming increasingly under hospital management regimes, and with patients less deferential and more conscious of their rights (even litigious), the old world of the emperor consultant is fading fast. *Tomorrow's Doctors* warns the modern trainee doctor that the patient is the master now—a trend that can only grow. What is missing is any sense of the ever murkier political shark pool in which doctors must practise. The document doesn't mention the growing interference, demands, and often perverse priorities set by politicians in the affairs of medicine. It doesn't warn or advise about how to cope with these, for surely as election after election is fought over the minute details of medical care, young doctors need to think about how to navigate these choppy waters, when to resist, and what to avoid. It doesn't instruct about private practice and its tricky interface with the NHS. Some trainees will have entered medicine intent on earning sizeable sums, though many will never touch a private penny. The document omits to mention the many ethical questions surrounding money and treatment—relating to NHS rationing priorities or private payment.

But if young doctors come out of medical school imbued with the ethos of this new framework for their education, then we might expect a new generation of hypersensitive, continually learning, thoughtfully cooperative doctors working together in a happy collective of medical harmony. If somewhere between aspiration and reality human nature intervenes, at least doctors can be sure that they will still be practising closer to their own codes of practice than most journalists do to theirs.

Polly Toynbee *political and social commentator, Guardian, London*

Searching for the good doctor

Looking on the internet for guidance on what makes a good doctor yields some unexpected results. Readers who can remember the 1970s will be pleased to find a site dedicated to legendary pub rock band Dr Feelgood (www.thegooddoctorfeelgood.com/). Perhaps the band's prescription of "Milk and Alcohol" would be of value for some purposes, but pending the long overdue report from NICE into its clinical effectiveness this cannot be admitted definitively into the pharmacopoeia.

The feelgood approach to defining what makes a doctor good presses "patient centredness" too far. There is more to clinical virtue than doing what most satisfies patients' desires and doing so efficiently. Yet there is a small step from the Dr Feelgood approach to that canvassed by many of the patient support groups on the net. For instance, Co-Cure's "good doctor" list for chronic fatigue syndrome and fibromyalgia (www.co-cure.org/Good-Doc.htm) lists doctors by country who are sympathetic to patients with a diagnosis of these conditions and who have access to the latest clinical trials of treatments. Whatever the status of these conditions, the idea that clinical goodness has to do with treating a patient's illness as the patient defines it is at the heart of the postmodernist trend of defining medical knowledge and skill by what the consumer demands.

Teasing out the difference between a late capitalist boutique medicine and medicine that is respectful of the autonomy and personal suffering of patients is remarkably difficult. The web offers little counsel here, save to refer us back to two rather traditional presentations of clinical virtue: exemplary narratives of clinical excellence, and professional codes of good practice and standards of competence. Most of the world's professional associations for doctors have placed their codes of conduct and ethics on the web, but perusal of these provokes the sceptical thought that compliance with a code is merely the outward form of medical virtue, not its moral heart. To perceive the moral heart of medicine, many scholars and practitioners are turning to the study of the medical humanities. A remarkable compilation of curricula for this subject has been published by New York University (http://mchip00.med.nyu.edu/lit-med/syllabi.for.web/syllabi.by.topic.html), and a UK site (www.mhrd.ucl.ac.uk/) has been designed specifically to complement it.

www.co-cure.org lists doctors sympathetic to patients with chronic fatigue syndrome

For some people the assurance that doctors are compliant with professional codes and versed in the humane side of their discipline will not be enough, and they will look to objective standards. But how do qualifications and league table positions correlate with quality, care, goodness? Not well: after all, to be struck off you must first register. Perhaps not at all: goodness, in the sense of being a good doctor, may not be a matter of degree at all. Pursuit of this issue leads into some very dense philosophical thickets: help is at hand at philosopher Lawrence Hinman's ethics update page (http://ethics.acusd.edu/index.html) and at the US National Reference Center for Bioethics Literature (http://www.georgetown.edu/research/nrcbl/).

The philosopher David Hume noted that all of this theorising was both irresistibly attractive and also somewhat depressing. He would unwind with a few games of billiards. In that spirit I set these questions of virtue aside and check the cricket scores instead (http://www.cricinfo.org/).

Richard E Ashcroft *senior lecturer in medical ethics, Imperial College*
r.ashcroft@ic.ac.uk

Doing better, looking worse

The portrayal of doctors in art, literature, and television

In Luke Fildes' memorable Victorian painting *The Doctor* a child lies ill. Her father looks helplessly on, while a far more imposing male figure gazes intently at his patient. The doctor broods, and in truth there was very little more he could do; we know now that he was almost as helpless as the parent, only six feet and three or four social classes away. So his manner is all, and Fildes captures it for ever: the furrowed brow; the hand propping the firm bearded chin; the calm, concerned authority.

For all their professional powerlessness, whole generations of our predecessors enjoyed similar esteem in the media of their day. The doctors of 18th and 19th century fiction offer many more heroes than villains: Tobias Smollett's ebullient protagonist in *Roderick Random*; the kindly Dr Lydgate in *Middlemarch*—idealistic and progressive, marrying upwards (in an age when medical men still used the tradesman's entrance) then driven to commercial practice by his wife's extravagance. And in Charles Dickens's *Bleak House* the decent young Dr Woodcourt—an altruist in the slums at first, forced by poverty to emigrate, thence the hero of a shipwreck, and at last deservedly blessed in both marriage and fortune—stands in honourable contrast to the lawyers of the piece.

Through early Somerset Maugham in the 1890s—a doctor moved to pity amid the low life of London in *Liza of Lambeth*—and A J Cronin's *The Citadel* (and his other novels of the 1930s), there is idealism still, fired by the brute realities of darkest London and the coal owners' hegemony.

Are there serious medical villains I've missed? And did medicine ever attract the scorn of pre-modern satirists for anything worse than pompousness or minor folly? The generic fictional doctor and most of the specific exemplars I can think of are diligent, tolerant, worthy, discreet, and no greedier than their circumstances might justify. Many are more than that: friends of the sick, champions of the poor, and even ahead of their times politically.

In the early 1950s a young London anaesthetist caught another mood in fiction that was jovial rather than elevating, and later also filmed. Richard Gordon's merry band in *Doctor in the House* owes as much to P G Wodehouse as to Maugham or Cronin, but his clubbable young men and their genially grotesque seniors found and pleased readers by the million half a century ago in the glad springtime of the NHS.

Since then the continuing rise of science based medicine and a new culture of scrutiny and accountability have coincided with a more complex and far darker portrayal of our profession and what we do. Yes, briefly there was simplistic triumphalism: television's Dr Kildare was handsome, crisp, and effective. But increasingly over the decades since, doctors as entertainment have acquired problems, anxieties, and worse. Was it in reaction to our own overselling of the scientific revolution or simply (in its most pervasive manifestation) a convention of the television soap that the flawed professional—the doctor of course included—is now the standard item? Perhaps it was both.

May I declare an interest here, and while I'm at it plead slightly guilty? In my misspent youth I wrote a novel (*The Houseman's Tale*) about junior medical life. My doctors were decent enough, though broadly but not uniformly imperfect, and in the lay press the book got good marks for realism. Then it was savaged over a full page in the *BMJ* by a senior house officer in Lancashire whose main point was that this sort of stuff is all very well among ourselves, but not, please not, in front of the patients.

REX FEATURES

Dr Kildare

I thought about that, and disagreed: the patients as public were paying for it all and had a right to know, and sadly no real right to expect perfection. But I sometimes wonder what my tense young critic of 25 years ago is making of more recent fictional portrayals of medicine.

Did Jed Mercurio's *Cardiac Arrest* give him exactly what it said on the label? And what might he make of the same author's recent novel *Bodies*? Literary criticism folk have a phrase for the genre: something like-"transgressive sordid hyper-realism." It is new to the portrayal of medicine, and I rather admire it. The blithe spring of the NHS is a long way behind us now, and the lives of junior doctors infinitely less supported and more stressful than once they were. *Bodies* is therefore a tale of sweat, grime, dead-soul sex, drug misuse, abuse of power, and ultimate disillusionment. Idealism it isn't; more like graceless defeatism.

So, with medicine now infinitely more potent and doctors more available and effective than ever before, the way we are portrayed offers little comfort and much cause for thought. We have promised much. We are expected to deliver and damned when we don't. Disappointing, flawed, and suspect—in fiction as in life—we draw our pay and lie low, and would of course be astonished to be treated with a fraction of the respect once paid to Fildes' powerless demigod.

And if, in the depiction of our trade, perceptions of our benignity and those of our power have been locked in a dispiritingly inverse relationship, what, if anything, can be done? Is it too late to think the unthinkable? Still wielding our modern wonders, should we not now look backwards too, learn from the great Victorians, cultivate presence and consideration at all levels, and mend our bedside manners?

Colin Douglas *doctor and novelist, Edinburgh*

THE ART ARCHIVE/TATE GALLERY, LONDON

Luke Fildes' *The Doctor*

The Doctor's Dilemma

George Bernard Shaw

Penguin, £7.99, pp 192
ISBN 0140450270

George Bernard Shaw, in *The Doctor's Dilemma* (1911), both undermines and reinforces a rounded view of the good doctor. The play introduces one character, Sir Ralph Bloomfield Bonington—"cheering, reassuring, healing by the mere incompatibility of disease or anxiety with his welcome presence. Even broken bones, it is said, have been known to unite at the sound of his voice." Sir Ralph (known as BB) is kindly but sadly deficient in medical knowledge. The play's physician protagonist, Sir Colenso Ridgeon, is able to murder the husband of the woman he desires to wed simply by referring him to BB for anti-tuberculosis treatment. If BB gives the mistaken impression that one can have competence or beside manner but never both, Shaw sets the reader straight in his preface. He makes clear, by savagely attacking their absence, that both scientific acumen and compassion are necessary qualities of the good doctor. Shaw includes under "science" both a clear understanding of biological mechanisms and the statistical study of outcomes, placing him in synchrony with today's evidence based medicine. He also devotes nearly a quarter of his preface to attacking vivisection because he thinks that a profession that would justify the torture of animals cannot be trusted to treat humans compassionately.

Shaw sees huge deficiencies in both science and compassion in the medical practice of his day, but he does not blame doctors. Good doctors must practise within a good system, free of perverse incentives that push "wildly beyond the ascertained strain which human nature will bear." A good doctor would tell the idle rich patient that he needs for good health not a bottle of medicine but (Shaw quotes Dr John Abernethy, 1764-1831) to "live on sixpence a day and earn it." A good doctor would tell the poor patient that she needs for good health not a bottle of medicine but decent housing, clothing, and food, good air to breathe, and a host of other things she is quite unable to obtain. In both cases, doctors who are paid for providing drugs and who must compete with their fellows to attract patients would soon face poverty if they gave sound advice. Besides the poverty that affected a good portion of the profession in the early 1900s, Shaw saw as inhumane the demands on the doctor to be available for emergencies at all hours of day or night. Shaw's solution was a government financed system in which doctors were paid a salary to promote prevention and public health.

Returning today, Shaw might be pleased with how we had solved the problems of doctors' poverty and working hours. He might argue that we still have a long way to go in the science and compassion line—especially because he thought that a truly scientific and compassionate attitude would naturally breed humility, a virtue he might find in as short supply in today's medicine as in his own time.

Howard Brody *professor of family practice and medical ethics, Center for Ethics and Humanities in the Life Sciences, Michigan State University, USA*

Boys in White: Student Culture in Medical School

Blanche Geer, Everett C Hughes, Anselm Strauss, Howard Saul Becker

Transaction, $29.95/£23.50, pp 456
ISBN 0878556222

This book describes the pioneering 1961 study by Howard Becker and his colleagues of how "boys in white"—medical students—become doctors. It remains a remarkable ethnographic study of how these young men at the University of Kansas lived: their schedules, their efforts to find out what professors wanted from them in tests and exercises, their "latent culture" (the division into alphas and betas, fraternity and non-fraternity men); their slow assimilation of medical values through peer pressure and example; their learning how to negotiate a hospital or clinic in all its complexity; and their perspectives on their futures.

Much of this is still pertinent today, but my overwhelming sense in rereading this book is the same one I get rereading classic anthropology: the tribe is gone and with it many of its initiation rituals; and the anthropologist who can isolate his tribe from the surrounding world is gone too. The world that Becker and his colleagues report is not quite as distant as 19th century Paris or Vienna, but it is fading fast. The relatively comfortable, professionally self sufficient world of late 1950s' medicine in the United States is more and more a memory.

In the first place, there is the matter of gender. This book is self consciously about "boys in white"—the authors say that there were not enough women to worry about. As the percentage of women entering medical school approaches 50%—it was 45% in 1999-2000—all this has changed. How big a difference the dramatic increase of women in the profession will make remains to be seen, but everywhere in medical training and practice as well as in how medicine presents itself to its consumers much is made of new approaches and perspectives. In any case, the old male dominated world is fading, if not gone.

Then there is the question of professional autonomy. This book is about initiation into a system that was almost entirely self governing. Standards were maintained from within. The scene that the authors describe in which some students comment disapprovingly on the error committed by another—he inadvertently did an abortion because he failed to ask about pregnancy—would be inconceivable today. "Risk managers" would be on the spot. There would be much wringing of hands and much discussion of error, a topic on which the authors are silent. These students assume that they are entering a self monitoring world in which poor patients should be humble and other patients duly grateful. This world is gone.

Finally, the book conveys a curious lack of interest in how the outside world affects the tribe of medical students. Today's medical students are not so innocent of the great moral issues of their day as their counterparts were in the 1950s and early 1960s. I suspect that they are more caught up than were their predecessors with outside concerns: treating patients from radically different backgrounds, races, and languages and dealing with end of life questions and the social causes of illness.

BLAIR SEITZ/SPL

How "boys in white" become doctors

Today's tribe is not as isolated and self sufficient as that described by Becker and his colleagues, and today's social scientists are not as quietly self confident. In 40 more years *Boys in White* will have become a historical document.

Thomas Laqueur *professor of history, University of California, USA*

Words about doctors

However pressed [the doctor] may be for time, each patient should be made to feel that his illness is of real concern to the doctor. The general practitioner needs a deeply imaginative sympathy which enables him to understand his patient's fears, anxieties, pain and discomfort … He must be able to put himself in the patient's place."

The Training of a Doctor (BMA report, 1948)

"One of the fundamental reasons why so many doctors become cynical and disillusioned is precisely because, when the abstract idealism has worn thin, they are uncertain about the value of the actual lives of the patients they are treating. This is not because they are callous or personally inhuman: it is because they live in and accept a society which is incapable of knowing what a human life is worth."

A Fortunate Man (John Berger, Allen Lane/Penguin, 1967)

"Doctors came to see her singly and in consultation, talked much in French, German, and Latin, blamed one another, and prescribed a great variety of medicines for all the diseases known to them, but the simple idea never occurred to any of them that they could not know the disease Natasha was suffering from, as no disease suffered by a live man can be known, for every living person has his own peculiarities and always has his own peculiar, personal, novel, complicated disease, unknown to medicine."

War and Peace (Leo Tolstoy)

"Doctors cannot help anyone over a serious difficulty or even a minor affliction when they do no more than simply exercise the routinized skills of their particular discipline."

The Enigma of Health. The Art of Healing in a Scientific Age (Hans-Georg Gadamer, Stanford University Press, 1996)

"Anton Chekhov worked unhurriedly. Sometimes a kind of hesitancy appeared in his manner but he did everything with attention and a manifest love of what he was doing, especially towards the [patients] who passed through his hands. He listened to them, never raised his voice however tired he was and even if the patient was talking about things quite irrelevant to his illness. The mental state of the patient interested him particularly. As well as traditional medicine he attached great significance to the effect that the doctor had on the psyche of the patient, and on his way of life."

Doctor Chekhov (John Coope, Cross Publishing, 1997)

Submitted by Iona Heath *general practitioner, London*

PERSONAL VIEWS

Good doctor, bad doctor—a psychodynamic approach

Let's face it—we doctors aren't saints. Have we not all sometimes felt bored and irritated by certain patients, longing for the consultation to end? Can any doctor honestly say that he or she has never felt a flicker of sexual interest in a patient? Have we never—and post-Shipman it is very difficult to say this—imagined the death of certain patients and the relief that would bring, not just to them but to us, their impotent carers? Do we not at times resent the demands of people for whom illness seems to have become a way of life? Whose thoughts have not sometimes drifted off towards their own concerns—to the need for sleep, food, or distraction or to some family, career, or future plans?

Moreover, perhaps rather than being motivated by altruism and scientific integrity, we are merely using our patients to bolster our own fragile sense of competence and health. Most of us look reasonably healthy, physically and mentally, as we stride about "our" hospitals and surgeries, strong and powerful in contrast to the vulnerability and distress with which we are surrounded. Are we not treating ourselves, our vulnerability and fear, as much as our patients?

We are merely using our patients to bolster our own fragile sense of competence and health

So is none of us really fit to practise? In confessing to these failings, am I writing a professional suicide note? What are we to do with these normal human reactions? Are we to ignore them, repress them, speak out about them—or can we use them in the service of our work?

The crucial distinction is between thought and action. We aim, as far as possible, to be pure in word and deed, but we can allow ourselves to be as ugly as we like in thought. The more aware we are of our reactions to a patient—however bizarre, irrelevant, or unprofessional these may seem—the less likely we are to use the power imbalance between us to act in untoward ways. When bad things happen between doctors and patients it is usually due to a confluence of the unconscious needs of both. If the lonely doctor had been aware of and been able to articulate the extent of his sexual fantasies he would have been far less likely to end up in bed with his sexually abused and depressed patient. I often find that a few minutes' irreverent moaning about patients with colleagues before a ward round leads to better and more compassionate consultations.

The key to good doctoring is not regulation, but the ability to put ourselves in our patients' shoes

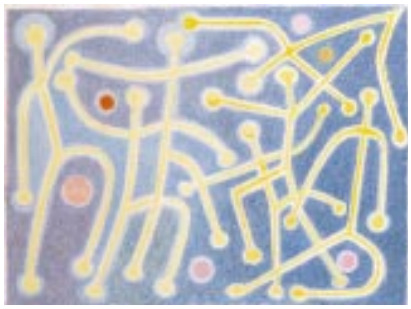
The feelings a doctor has, or actions he or she carries out in relation to patients, are often a manifestation of the patient's inner world, via a mental mechanism known as "projective identification." If a doctor is bored with a patient, this may be because the patient is feeling dull or uninteresting or is angry about something but cannot express the anger. Excessive worry about a patient may be the result of being infected by the patient's anxiety—but out of proportion to the objective situation.

The GMC prescribes do's and don'ts for doctors. Although these are undoubtedly useful, most doctors consciously subscribe to them anyway, and the question of why bad or harmful practice continues remains unanswered. I believe this is because, like all human beings, we are less coherent than we like to think, and are motivated by forces of which we are unaware as much as by the conscious wish to heal and do a good job. Ultimately the key to good doctoring is not regulation, but the ability to put ourselves in our patients' shoes—to imagine what it might be like to be on the receiving end of our treatment. There are many ways to acquire this capacity for reflexive practice: role play, listening to users' perspectives, being a patient (through illness or through therapy or counselling). "Balint" groups, widely used in general practice, attempt to explore doctors' feelings about their patients through facilitated case discussion. I believe that all doctors should attend Balint-type groups in their training.

The search for the good doctor is an illusion—our unconscious minds will make sure of that. The psychoanalyst Donald Winnicott reassured mothers that to be "good enough" was preferable to striving to be ideal. Mothers who are good enough provide children with the opportunity to learn to cope effectively with disappointment and failure in the context of love. Similarly, if we can without complacency bring our good and bad parts together to become a good enough doctor, we should be content. More importantly, so will our patients be, despite sometimes feeling let down by us.

Jeremy Holmes *consultant psychiatrist/psychotherapist, North Devon District Hospital, Barnstaple, Devon*

Doctors and patients dance together



THE BRIDGEMAN ART LIBRARY

The Dance, 1985 by Peter Davidson

Doctor and patient sway together in an eternal dance. They need each other, and you cannot describe one without reference to the other. I never had much need for doctors until I was 47, at which point I seemed to have the need for lots of them. Lying in bed in hospital all day I was able to observe them in their natural habitat. I learnt not to worry about staring because doctors do not see you except when it's your turn.

My favourite place in St George's Hospital in Tooting, London, was the smoking room, not just because I'm a nicotine addict but because this dingy, airless, stinking place was the one corner of my enclosed world that did not feel like an underfunded public school. We inhabitants were rebellious fifth formers, and the smoking room was the haunt where the teachers never came.

Chief smoker was Ron, who seemed to have every disease I've ever heard of and a few more besides. He'd been in hospital for four months and had arrived at the conclusion that all doctors were useless, or even worse, part of a conspiracy to keep him ill and out of the pub. Ron's followers would bring daily bulletins of incompetence and cruelty perpetrated by the men and women in their mayoral chain stethoscopes. Ron advocated confrontation with the medical ruling classes: always question everything, dispute every diagnosis, look for the hidden agenda, and ignore all advice unless it suits you. He adopted the Jeremy Paxman approach to his encounters with doctors: why is this lying bastard lying to me?

How can you be a "good doctor" to a patient who does not believe in the concept? I don't know, but I think Ron's grouchy attitude was in some ways better than the ever-so-humble-and-doctor-knows-best position of gormlessness, which, I must admit, I adopt. Oh yes, I paid lip service to the smoking miserablists, but on the quiet I was like so many English people, subservient and awed in the glamorous presence of the consultant as he (and it nearly always was a he) swept into the ward on his morning rounds trailing students with clipboards in his wake. I would anxiously prepare the questions I wanted to ask as the god approached my bed. But when he arrived he'd say something that threw me off guard, or whose meaning was unclear. As I tried to interpret it, I found myself stuttering and worrying that my queries were stupid. And then whoosh, he was on to the next sicko in the next bed. Later when I came to reiterate to visitors what the doctor had said, I came up with: "I'm not quite sure."

Doctor as enemy, doctor as authority figure, and then there's doctor as disease. After I came out of hospital I wrote an article about my experiences, which prompted a letter from a man whose friend had died from acute pancreatitis (the thing that got me). As you no doubt know, the main thing you can do to prevent recurrences of this is give up alcohol. My correspondent told me his friend would stop drinking three days before a check up at the hospital and then they would meet in the pub after his appointment. His assumption was if you can fool the doctor you can fool the disease.

So to all you doctors, let me apologise on behalf of us patients. We are often—and in myriad ways—not up to scratch. We are imperfect, as you are, but you are paid and we are not. It's your job to make a better patient and a patient better. How can you do this? By following Arthur Smith's 15 rules for doctors.

Arthur Smith *writer and performer, London*

Arthur Smith's 15 rules for doctors

1 Make sure no one dies and everyone gets better
2 Do not be embarrassed to say, "I don't know"
3 Use metaphors, but make sure they make sense
4 Acquire an illness once a year and subject yourself to a week in hospital
5 Try not to turn up to work with a hangover
6 Remain forever curious
7 If, as a medical student, you feel the need to do a revue at the Edinburgh Festival, make sure the women have decent parts
8 Know your onions, and if you don't, admit it and ask the onion specialist
9 Be utterly candid except for the times when it's best to lie through your teeth
10 If you're male, be in touch with your feminine side. If you're female, the same applies
11 Heal, don't judge
12 Know that I consider myself the most important person in the world and that my pain is worse than everyone else's
13 Only wear a bow tie at the Christmas party
14 Get some sleep
15 Remember that Ron has a heart of gold really

SOUNDINGS

The good doctor

How do you define the good doctor? How do you solve a problem like Maria? Being kind and compassionate is all very well but we need more, the rage to achieve, the pride not to accept defeat; like Milton's Satan, our vices are indistinguishable from our virtues. The qualities demanded are multiple, and they fluctuate with time and circumstances.

Jennie had an unusual form of high spirited and happy dementia, and just as I arrived at the farm she was bolting out through the door, over the wall and across the fields. Her family came tumbling out after, but seeing I had arrived they stopped and looked at me expectantly, like the Council of Elrond looking at Frodo and thinking, "Here comes a real sucker, problem solved."

But being a good doctor, I accepted the metaphorical baton and set off in pursuit, leaping the wall and tipping over the other side, though luckily my fall was cushioned by some broken bottles. I could see Jennie in the distance, a glimmering girl fading in the brightening air among long dappled grass, dodging behind the dread vista of a fine herd of Jersey cows.

The cows represented a serious escalation. If you are ever hunted by the law, and have to escape across the fields, choose a field with cows.

City folk mightn't appreciate this, but cows are intelligent creatures and get bored standing around in the field all day. An exciting chase is a welcome diversion, so the herd galloped over for a better look. The avoidance of stampeding cows is not something we are taught in medical school. I swiped at them uselessly with my black bag.

Distracted, I then trod in a cow pat so large and liquid that a small boy could swim in it, a triumphant digestive mound that would have felt quite at home in the Augean stables. The quarry may not mind running through cow dung, but the sartorial demands of our profession leave us ill equipped for this task. And once dung gets on your clothes, the smell will endure forever; trust me on this point.

I caught Jennie at the far end of the field.

"Ah, doctor," she said playfully, as I grabbed her desperately by the ear, "I thought you'd never catch me."

A good doctor is a doctor who can run fast and is not overfastidious regarding personal hygiene. QED.

Liam Farrell *general practitioner, Crossmaglen, County Armagh*